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KZ-syndrome

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Some 15 years ago Dr. Stanisław Kłodziński, former Auschwitz prisoner, turned to several colleagues from the Department of Psychiatry, Academy of Medicine, Krakow, with the suggestion to study the problems of concentration camps. The suggestion was met with some resistance. The resistance seemed to be justified. There were doubts whether people who had not experienced the concentration camp would be able to understand those who survived the hell. Would survivors be ready to talk about themselves with non-prisoners? Would it not be cruel to ask them to recover their painful memories? How can we build an image of the camp? Do people have enough imagination? etc. Resistance originated in a feeling of incapability to encompass problems crossing beyond the borders of human issues.

The Krakow "Auschwitz Club" helped to get in touch with former prisoners and meeting them stimulated us to undertake these difficult problems. Interviews were promising. Those people, seemingly the same as others, appeared to be different. Their "otherness" becomes evident when they start talking about the concentration camp; they become more expressive with sparkling eyes, and seem to be younger - in the years that passed since they left the camp, everything has become vivid and fresh. They could not get out from the camp circle, there were the horrible things in that circle, but beautiful too, the bottom of human humiliation, and human goodness and gentleness. They possessed the knowledge of human beings, and in spite of this, or maybe because of it they are tormented with the mystery of the human being. They want to know how it happened that so much evil could be concentrated on the small territory of camp, and how a human being could overcome all this, or could oppose it. They are a mystery for themselves, and also, they feel the mystery of human nature, mystery and the misleading character of human forms, norms and appearances. For them "the king is nude".

Rapport with these people appeared to be easier for psychiatrists, than with those who never "touched" the bottom of human existence. The psychiatrist is in a search for answers to the question on the real nature of the human being, beyond a mask or mimics, gestures and words. The psychiatrist feels a good rapport with the patient if their talking together becomes honest and free from masking. The people who survived the camp often ask themselves too, what a particular person is really like, how he would have behaved in the camp, what would have happened with his dignity, rightness etc., if he was "there". Shared dislike for appearances and masks was bringing psychiatrists and former prisoners together.

Every prisoner could say what Maria Zarembińska said:

"I saw such terrible things, such horrifying human misery, such disappearance of everything human, and such simple pure heart reflexes, that I can openly say, I saw everything a human being can see and live through in a hell and in heaven."

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The first records of interviews with former prisoners aroused a few doubts: how it would be possible to construct from individual life histories a generalized picture of people who "saw it all", being a summary of experiences almost impossible to communicate. Individual histories of life before incarceration, individual camp experiences, and life history after concentration camp should be reconstructed. It also was unsure whether this method would be objective enough to meet the criteria of scientific research. It was based on ability to empathise with those interviewed. Many experiences were blurred or distorted in their memory. In efforts to generalise features of former prisoners, they were losing their individuality. It was difficult to identify the most significant details in the accumulation of information. Statistical analysis did not always honour the individual factor. Such doubts and questions appeared many times when life histories of the first group of 100 former prisoners were analysed. Later the group studied was extended to include several dozen of "Auschwitz children", people who were born in concentration camps, or were incarcerated in their childhood. Their problems were found different in comparison with "adult" prisoners, nevertheless some features were common.

An encounter with a person who survived the camp arouses many questions in every psychiatrist. Often it touches the basic essence of the psychiatrist's professional orientation. The essential question every psychiatrist tries to answer hypothetically is - what is the nature of a human being? It seems there is a difference in the answers formulated by psychiatrists who never met a concentration camp survivor, and those who did. It is a matter of familiarizing with human beings in borderline situations, which creates new, often unpredictable perspectives. This widening of psychiatric perspective caused a lot of problems when meeting with the scientific approach. Stereotypes of psychiatric thinking often had to be abandoned.

Contact with former prisoners had not been finished by the end of the first study. Survivors had been coming for medical consultations. They had been interviewed in a structured way. A large group of survivors, victims of pseudoscientific experiments while in the camp, was carefully studied in the Department of Infectious Diseases, Academy of Medicine, Krakow under supervision of Professor Władysław Fajkiel and Dr. Maria Nowak-Gołąbowa. Psychiatric and electroencephalographic examinations form an important part of these multidimensional studies. At the Department of Psychiatry, Academy of Medicine, Krakow, up until now, some 1500 former prisoners had been examined.

Further studies, in general, confirmed what was seen in analysis of life history of the first 100 survivors studied. Results of the studies carried on in other centres were also congruent with these first observations. This is a proof of reliability of psychiatry research methods, which psychiatrists themselves are often fooled by.

Ten years of studies and observations provided some evidence and encouraged an attempt to describe characteristics of people who survived concentration camps. The first researchers who assessed the former prisoners' state of health immediately after the war, had noticed such characteristics which allowed them to identify these common features as "progressive asthenia" (*asthénie progressive*), "post concentration camp asthenia" or "concentration camp syndrome" (*KZ- syndrome*). It is interesting especially as pathological features observed in survivors as a consequence of imprisonment were different both in physical health status as in mental health status. For example, some former prisoners developed premature coronary arteriosclerosis as a consequence of imprisonment, while others, brain arteriosclerosis, or pulmonary tuberculosis. The consequence of concentration camp imprisonment could be chronic digestive tract diseases, arthritis, precocious involution, persistent neurasthenic, anxiety-depressive syndromes, alcoholism, epilepsy etc.

In some cases, tracing the causal relation of disorder from the imprisonment in concentration camp is easy, in some, it requires meticulous analysis. Often post concentration camp consequences only appear more then a decade after leaving the camp. Nevertheless, the fundamental question is what is specific, among those various pathological consequences, what allows describing them with the common name: "post concentration camp syndrome" or "post concentration camp disease".

Of course one can provide a simple answer: the common aetiology - imprisonment in con-

centration camp. However, it does not seem to be essential. Everybody who met concentration camp survivors is struck with their similarity, difficult yet to catch and describe. They differ among themselves, and suffer from various diseases resulting from their stay in concentration camp, but still have something in common. This was, one can presume, the main reason the first researchers introduced the terms "KZ-syndrome" or "progressive asthenia". This was also evident in the Kraków Study, and became even more evident later. That is why all physicians studying physical and mental health consequences of concentration camp imprisonment introduced the term "concentration camp syndrome" into the health disorders classification and terminology. This describes a separate diagnostic entity of defined aetiology, characteristic, however, of a differentiated clinical picture, and specific therapeutic procedures.

In spite of the specificity of concentration camp survivors which has been felt and noticed immediately after the war, ten years later, and even now, a quarter of century later, it is still not easy to describe. Definition of "concentration camp syndrome", "post concentration camp disease", or recognised under yet another, more accurate name, it cannot be limited to enlisting of symptoms which result from concentration camp imprisonment. Such inventory would be endlessly long. What should be done is to attempt to define this undefined specificity, which is the factor bringing various symptoms and various people's characteristics to the common denominator. This specificity gave impulse to creating the name KZ-syndrome. And, is felt still, after the quarter of a century, and maybe even more evidently than immediately after leaving the camps.

What is felt very rarely appears to be easy to define. That is why, in spite of many studies the essence of "concentration camp syndrome" is still difficult to describe. There is something common for all concentration camp survivors specific for the syndrome, still undiscovered. It seems that neither hard criteria of *KZ-syndrome*, nor characteristics of survivors can be established without going to the beginning, that means to the actual stay in the concentration camp. But, these are problems overwhelming human imagination, and maybe even the human ability to empathise. Nevertheless, this first and fundamental step is necessary if "concentration camp syndrome" is to be described.

Abundance of concentration camp literature allows for an imaginative picture of the camp life. But still, this is an unclear picture, far from reality. The researcher is, to some extent, in the position of Mrs. Gudrun, described by Gawalewicz, who, after listening to histories of many concentration camp survivors she cared about, asked them if they had night lamps by their beds in camps. It seems that the abyss between camp survivors and those who had not experienced it is not crossable. Nobody is able to feel what they had gone through. Their experience is beyond human understanding (Jaspers's *verstehende*).

Psychiatrists should not, however, postpone efforts to cross these borderlines; even if they are not always successful in empathising with a mentally ill person's experience, psychiatrists had to achieve at least some understanding of the patient's inner life phenomena. Applying this approach to concentration camp experience one should take into account three aspects, as it seems crucial for the further fates of prisoners. These are: extraordinary span of camp experiences, psychophysical unity and concentration camp autism.

Entering into the hell of the camp was a shock beyond the normal stresses of human life. All authors writing on concentration camp experience emphasise appearance of the first reaction for imprisonment, which often ended with death. The prisoner had to adapt to the camp life during the first several weeks or months; otherwise he/she was lost. Two problems were important for adaptation. The prisoner had to anaesthetise himself/herself for everything that was going on around him/her, to withdraw and become indifferent, however without achieving a state of "muslim"- total apathy. This defensive anaesthesia has been connected here with the term "concentration camp autism". At the same time prisoner had to find, in the hell of the camp, his/her "angel", person or a group of people who still approached him/her in a human way, allowing for saving remnants of the former world.

It seems that finding another human being was the shock equal to that of entering to the camp. This was a positive shock, the heaven in the hell of the camp. A human being can never live in

one colour. The blackness is always accompanied by the whiteness. However, here the discrepancy between opposite colours of life was shocking; these were not contrasts of normal life, but true hell and true heaven. Masks were falling down; a person stayed naked. This was a very specific psychiatric experiment. What normally was hidden in a human being became revealed, his/her criminality and his/her holiness.

A psychiatrist, performing his profession, touches the "underpin" of human nature; in concentration camp his "underpin" was on the top. That is why concentration camp survivors are usually more sensitive to the authenticity of human relations; they feel the best among themselves, as they have common language, and find other people unreliable a little bit. Personality changes described in survivors resemble, to some extent, those observed after psychoses, especially the schizophrenic type. Both cannot get back to firm ground after their experience. The scale of their experience was to huge to allow them to fit in the average colours of normal life.

The world till now, together with its values, ideas, important and trivial problems was dissipating in ruins in the *anus mundi* of concentration camp. The world was becoming unreal; was coming back in nightmares; it seemed that such a world is possible on another planet only. When the known world falls apart, a human being feels lost, flooded with anxiety, is unable to project himself/herself into the future; the feeling of hopelessness arises. In such a situation another human being's smile, warm word, or simple help were becoming a piece of heaven, opening perspectives for the future, bringing back beliefs in one's own and other people's humanity. Since that moment, no other encounter with a human being, before or after the camp, had been equal to this specific illumination of meeting another human being in the hell of concentration camp.

In normal life conditions human relations are becoming more or less conventional; one rather passes by the other people then lives with them; the mask of social forms guards entering a sphere of intimacy with others. That is why people feel lonely having good relations with others. It looks like a paradox, but in the concentration camp, a feeling of loneliness was less than in normal life conditions. Survivors feel better among themselves, among companions in suffering; in this community their feeling of loneliness and not being understood disappears. It was in the concentration camp that they experienced meeting the other human being. This meeting often saved their life, turned them back from being only a number to human existence.

The role of interpersonal contacts in the concentration camp differed significantly from those in normal life. A simple human gesture, unnoticed in normal life, as a usual form of cultural behaviour, was an illumination in the concentration camp, showing a piece of heaven, often saving a life, bringing back belief in life.

Thesis on the psychophysical unity of the human being, fundamental in medical thinking, is verified at two points of life: at its beginning and its end, but also in terminal situations. In small children and in senile people the subjective is closely connected with the objective, mental breakdown leads to physical breakdown, or even death. The same happens in terminal situations. In terminal situation, one is also close to death, and when the subjective integral of all functions of one's organism, one's mental life, gets broken, everything gets broken. A prisoner who did not want to live any longer was usually not alive the very next day, or was entering a state of "musilm". But a cordial word from other prisoner often was life saving. Maybe the role and essence of psychotherapy appeared nowhere so evidently as it did in the concentration camp. If prisoners were recovering from serious disorders in camp hospital (at the time it was dominated by political prisoners) it was not due to medicaments which were scarce, but due to the attitude of colleagues-prisoners: physicians, nurses and other patients. This was probably the most beautiful chapter in history of psychotherapy. The true "therapeutic community", so much discussed in psychiatry today.

The concept of psychophysical unity, so obvious for every physician, is seemingly unconvincing, as incongruent with splitting between *psyche* and *soma*, physical and mental activities, natural for everybody; one are objects, the other subjects. It can be presumed, that this splitting is, at last to some extend, expression of organism steering functions. The relation between steering and being steered is always formed as a subject - object one. In the human organism only a small part of

extended and very complicated steering activities reaches consciousness, others are automatic from the beginning (e.g. vegetative activities) or become automatic in consequence of repetition (e.g. walking). A child, learning to walk, is aware of every movement of this function; the struggle between the subject aiming to learn a new function (walking) and all this which opposes this new task. With learning a new function the struggle diminishes; moves to the new tasks (e.g. function of writing). The function that learned becomes an obedient "object", "a physical function", "body"; an act of will ("I go") is enough to the body, which obediently performs it. For a dancer, or mountain climber the struggle continues; each movement requires consciousness. This is not only a physical function, but also a mental one. Their bodies are in a sense "spiritualised", that means consciously experienced. Thus, the split between subject and object is connected with a permanent struggle for new tasks achievement, with transformation of potential functional structures into realised structures.

In concentration camp the functions which were automatic for long, have became a struggle field again. Each step, every body posture, gesture of the hand were becoming important, often gaining a decisive moment in one's life. Eating and relieving physiological needs occupied a primary position in the prisoner's consciousness. Using psychoanalytic terminology this can be described as a regression to infantile period of life when the child is learning to perform theses activities, and in consequence they occupy a central position in the child's experience. This could explain a maternal character of the emotional bonds between prisoners; a kind, cordial gesture gained a potency of the maternal one. Therefore the will to survive was so important for staying alive. Every movement was of importance, one had to fight with oneself all the time. When a prisoner lost his/her power to fight it could be seen in his/her eyes.

"These eyes, heralds [of death] in the camp - wrote Professor Stanisław Pigoń - were a separate problem. I had seen more of them I could cope with. We had learnt their meaning by experience. As a farmer looking at a sunset in clouds can forecast bad weather next day, we were also able to recognise the quietly approaching death from the way one of us was looking around. We could say who will be dead in three days".

The split between *soma* and *psyche* disappeared in concentration camp. Loosing inner tension connected with the need to survive usually marked the end of life. A "muslim" state was a typical example of giving up the fight.

Physicians find it difficult to assess late health consequences of concentration camp imprisonment, as the causal relations are not easy to identify. There is a problem whether praecox involution, tuberculosis, cardiac disease, neurosis, alcoholism or epilepsy really are consequences of the concentration camp sufferings. The symptoms of the disorder may appear many years later. Does absence of immediate sequence allow for identification of a causal relation? What aetiological factors participated in the development of post-concentration-camp illnesses: hunger, mechanical traumas, infectious diseases, mental traumas, etc.? Such questions challenge psychiatrists preparing expertises concerning former prisoners. It seems that the concept of psychophysical unity of the organism, dramatically revealed in the camp, makes answering these questions easier. Exceptional mobilisation of the whole organism, necessary in concentration camp conditions and expressed in consciousness as a tendency to survive against all obstacles, was probably the main aetiological factor. Normally, the human being is unable to withstand such mobilisation for a longer period of time. Sudden death due to extraordinary mobilisation of endocrine and vegetative systems were described (observations of Cannon, Selye based his concept of stress on). Other factors had their role too, of course; hunger above all; but all of them were leading to extreme mobilisation of the organism. For one, hunger was unbearable and led to a "muslim" state; for the other it was a torture domineering all thoughts, but torture the prisoner was capable to oppose. Finally all was reduced to the fight with one's own body inertia.

If causal relations are under consideration it does not seem reasonable to separate mental factors from physical ones. Both were connected so closely, that their separation is artificial. Hunger, infectious diseases (especially exantemathic and abdominal typhus), head traumas etc., could result in permanent destruction of the central nervous system. Such destruction could

have, for years, symptoms of a chronic neurotic syndrome. Symptoms of an organic brain syndrome can be seen many years later, and only then is the physician able to identify aetiology, which was so easily overlooked earlier on. On the other hand, chronic mental tension of concentration camp life could precipitate praecox arteriosclerosis or lead to immunology deficiency. After the years, some of the prisoners produced somatic symptoms, or mental symptoms, then only identified as the late consequences of the concentration camp. In such a case, psychological trauma evidently caused physical syndromes. Such deliberations are of theoretical value only; these factors cannot be separated in practice. The problems of causality can be discussed only as a whole.

From a medical point of view, the extreme mobilisation of the organism mentioned above, which was a condition of survival in the camp, must have left consequences. But how to explain the fact, that there was a group of former concentration camps prisoners who did not need any medical help for years. Only a part of them, many years later, manifested somatic or mental symptoms which could be diagnosed as late consequences of imprisonment in the camp. Symptoms of premature involution were the most visible. But still, there are survivors in very good health and well-being, more active and vivid then those who did not experience the camp. Medicine has no explanation. Could more subtle research techniques find some pathological changes caused by the life in the camp? From a theoretical point of view such changes should exist. Chronic and strong stress of the concentration camp has to leave traces in an organism. But, these traces can be latent for many years and show up suddenly after banal physical or psychological events.

These traces can be found with a precise psychiatric examination as more or less discrete post-concentration-camp personality changes, problems in adaptation to normal life conditions, changes in basic life attitudes and hierarchy of values, regarding the camp as a fundamental reference system, nightmares about the camp life, hypermnesia concerning the camp etc. These are, of course mental facts, but having in mind the concept of psychophysical unity, so dramatically manifested in the camp, they should be regarded equal to physical manifestations.

In order to understand how it was possible to survive the concentration camp and maintain good health, one should turn back to the time in the camp and try to answer how survival was possible at all. Undoubtedly, the prisoners had to become indifferent to various experiences, unbearable in normal life. They had to withdraw in order to find in oneself the strong point of support and belief in survival. Religious believes, conviction that evil has to come to an end, that justice will be done to their prosecutors, thoughts about family and the loved one's helped to survive.

Professor Stanisław Pigoń beautifully wrote about it in his "Recollections from the Sachsenhausen camp":

"Old fortresses used to have a two-story. Above the "lower castle" there always was the "higher castle", on solid rock. When the lower castle was conquered, the higher still could be defended for long. The old brigand gave Rafal Olbromski a good advice while in the Orawa prison: "keep strong". We too, were confronted with evil abuse, had to find in ourselves such a "higher castle", the base never to be destroyed, and cling to it with our might, never loosening the grasp. We could never allow ourselves to doubt or fall in prostration. We had to hide in the most distant corner of our soul and remain there as the stone in the soil. Let them blow me up. There was our salvation. These are not empty words. I found myself such a point of support and that is why I survived. What was this point it does not matter here, but it was, and it formed a shelter against the onrush of hatred. Such a defence system does not depend on age, nor on vital resources".

For a psychiatrist there is something of a schizophrenic autism in such a phenomenon; the surrounding world becomes unbearable, the human being withdraws, cuts off exchange with his environment, lives within his own world, which step by step or immediately reaches a value of reality. Therefore, the term "concentration camp autism" is adequate. Of course, it was not the total autism. Relations with friends and colleagues, this light in the hell of the camp, had an essential role in survival. But this was a general phenomenon and condition for "adjustment" to the camp

life. As in schizophrenia "rich" autism is differentiated from the "poor" one, so in the camp besides these who had found their "higher castle", there were those who could not find it. Professor Pigoń wrote about them in these words:

"Since I am talking about tactics in prisoners salving themselves from the avalanche of evil and extermination, I have to mention one method I never dared to assess: was it more difficult or easier then described above? Higher or lower? Anyhow, it was rare to find such a one who dared to try it. It was a peculiar kind of ataraxy connected with a specific inner petrification, difficult to understand. The prisoner who had reached this attitude was called - with pity and disdain - as "muslim". It was a specific product of the camp conditions. At the bottom of disregard, in total apathy to death, such a prisoner was able to overcome and suppress the suffering and never step back in front of shrillness of pain. There was one such in our barrack, I watched him terrified. Emaciated, hardly able to move, without hesitation he went with a persistent challenge: "Come, and try to kill me". And it happened that the devil of cruelty turned away his angry eyes and walked away defeated. I saw it".

It is surprising, that former prisoners found it more difficult to adjust to life after the camp that to the camp itself. Such situation resulted from a number of objective facts. There were many unfulfilled expectations and hopes. For years their suffering and heroism were not seen and valued. Everyday problems of life seemed trivial in comparison with their camp experience. Forms of social relations shocked them with hypocrisy and narrow-mindedness. As a patient recovering from acute schizophrenic psychosis slowly comes back to normal life, perceiving everything as grey and trivial in comparison with psychotic experience, so people "from there" have not been able to adapt again to normal life for months and even years.

There are limits of human experience which cannot be gone beyond, without consequences; if it happens, if the line is crossed, there is no come-back to the previous state. Something had changed in fundamental structure; the person is no longer the same. This difference is usually referred to as "a personality change", in the case of schizophrenia a technical, and unsuitable for a human being term "defect" is often used.

The personality changes observed in concentration camp survivors concern three dimensions: 1- general life dynamics, subjectively perceived as mood, 2- attitude towards other people, and, 3- ability to restrain. Decrease of mood, distrust towards others and lowered ability to restrain (hypersensitivity and irritability) are the most often to be found. Changes in opposite direction also happen: increased dynamics, trust in people close to naivety, and increased restrain in the form of "unmovable balance".

Those who have relatives and friends among former concentration camp prisoners must have sometimes experienced an unpleasant feeling that they cannot understand each other; that former prisoners feel better among other survivors then with family members or close friends from the time before the camp. "Among themselves", that means companions from the camp they are lively, open, forget about social hierarchy and related forms, and have a specific camp humour. Not all survivors keep in touch with other former prisoners; there are such, who avoid these contacts, as well as all memories of the camp. These survivors were not able to "digest" the camp yet; the camp experiences are still too painful for them to return to.

Every human being has the "islands" of memory he/she is keen to come back to, or which emerge from oblivion, even against one's will. Various islands; bigger or smaller, nice and ugly, appear depending on mood and the present situation, sometimes without any identifiable reason. For former prisoners these are not many small, but one huge island, which does not allow to see the other ones. This island became the basic reference point in post-camp life of former prisoners. It changed their attitude towards life, the hierarchy of values, attitude towards other people, influences their life goals, and comes back in nightmares with tormenting regularity. One is unable to let go.

During the Second Medical Congress of ZBOWiD, May 28-29, 1968 a postulate was put forward, that due to specificity and individuality of its clinical syndrome, the so called 'post-camp syndrome' (*KZ-syndrome*) which was recognised in the scientific world, should be included into the international classification of disorders and given a specific statistic number, which, among other reasons, would be important for medical

expertises. As terminology of the syndrome is not unified, the unification should be done by professionals, that means ZBOWiD physicians and linguists as consultants".

At analysis of health consequences of concentration camps one should step back to the imprisonment period itself. Three factors, as this work suggested, are of importance: the span of experiences ("hell" and "heaven" of the camp), psychophysical unity, dramatically manifested *in extremis* of the camp life, and the specific autism based on finding in oneself a point of support enabling survival. Specificity of Nazi concentration camps influences specificity of post-camp disorders. In spite of many similarities they are not identical with consequences of internment in the camps for military captives (so called "barbed wire disorder") or concentration camps of other type. Therefore the term *KZ-syndrome* seems to be, at least temporarily, the most adequate.

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